

**CASE MANAGEMENT  
RELEASE OF INFORMATION**

Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_

SSN: \_\_\_\_\_ Medicaid# \_\_\_\_\_

I understand that my consent is voluntary and can be withdrawn at any time by writing my case management provider. This consent for release of information will end at the time case management services are discontinued or upon my request.

I understand that I have the right to refuse to sign this consent for release of information. I understand that 1) this consent will not affect treatment, payment, enrollment or eligibility for benefits and 2) information disclosed as a result of this consent may be re-disclosed by the recipient as authorized by law.

I, \_\_\_\_\_, client or parent/guardian of, \_\_\_\_\_  
do hereby authorize my case manager, \_\_\_\_\_ to release  
the items checked below to \_\_\_\_\_ for the purpose of \_\_\_\_\_

☐ Initial Intake      ☐ Family Needs Assessment      ☐ Service Plan  
☐ Follow-Up Form      ☐ Social History      ☐ Other  
specify: \_\_\_\_\_

Furthermore, I do hereby authorize \_\_\_\_\_ to release the  
following items checked below to my case manager \_\_\_\_\_

☐ Medical information      ☐ Psychological reports      ☐ Educational plan  
☐ Developmental information      ☐ Legal information      ☐ HIV-related information  
☐ Other,  
specify: \_\_\_\_\_

I do not want the following parts of my/my child's records released:

\_\_\_\_\_

\_\_\_\_\_  
Client/Parent/Guardian\_\_\_\_\_  
Date\_\_\_\_\_  
Interpreter\_\_\_\_\_  
Date